EvidenceNOW
Advancing Heart Health in Primary Care

North Carolina Cooperative

Heart Health **NOW!**

EvidenceNOW: Advancing Heart Health in Primary Care is an initiative of the Agency for Healthcare Research and Quality (AHRQ) to transform health care delivery by building a critical infrastructure to help smaller primary care practices improve the heart health of their patients by applying the latest medical research and tools. EvidenceNOW establishes seven regional cooperatives composed of public and private health partnerships that provide a variety of quality improvement services typically not available to small primary care practices. The goal of this initiative is to ensure that primary care practices have the evidence they need to help their patients adopt the **ABCS** of cardiovascular disease prevention: **A**spirin in high-risk individuals, **B**lood pressure control, **C**holesterol management, and **S**moking cessation. The initiative also includes an independent national evaluation designed to determine if and how quality improvement support can accelerate the dissemination and implementation of new evidence in primary care.

Cooperative Name:
Heart Health NOW!
Advancing Heart Health
in NC Primary Care

www.hearthealthnow.org

Principal Investigator:
Samuel Cykert, M.D.,
University of North Carolina
at Chapel Hill

Cooperative Partners:
University of North Carolina at Chapel Hill, Cecil G. Sheps Center for Health Services Research

North Carolina Healthcare Quality Alliance

Community Care of North Carolina, Inc.

North Carolina Area Health Education Centers Program

Geographic Area:
North Carolina

Project Period:
2015-2018

Region and Population

North Carolina's population of over 10 million is racially and ethnically diverse, with 71.5 percent White, 22.1 percent African American, and 9.0 percent Hispanic.[1] The burden of cardiovascular disease (CVD) in the State is large, and almost one-third of deaths are caused by CVD (the CVD mortality rate is 251 per 100,000).[2] CVD risk factors are common among the population; 65 percent of adults are obese/overweight, 32 percent are hypertensive, nearly 10 percent are diabetic, 20 percent smoke, and 54 percent do not meet physical activity targets.[3] Only half of patients treated for hypertension currently have their blood pressure under control, and only half of patients aged 40 to 64 with elevated cholesterol have been treated to recommended levels.[4]

Specific Aims

Evaluate the effect of primary care practice support on:

1. Evidence-based CVD prevention
2. Patient-level health outcomes
3. Implementation of clinical practice and office systems changes to improve evidence-based CVD prevention
4. Practice capacity to implement new patient-centered outcomes research (PCOR) findings

Reach

- Goal for Number of Primary Care Professionals Reached: 750-900
- Goal for Population Reached: 1.13-1.35 million

Agency for Healthcare Research and Quality
NATIONAL CENTER FOR EXCELLENCE IN PRIMARY CARE RESEARCH

EvidenceNOW
Advancing Heart Health in Primary Care

North Carolina Cooperative

UPDATES ON KEY PROJECT COMPONENTS

Support Strategy

All practices will receive 12 months of intense practice support, including onsite quality improvement facilitation, academic detailing (expert consultation), and electronic health record (EHR) and health information exchange support. Components of the practice support will include:

- *Optimizing the use of the EHR* to extract clinical quality data on a monthly basis to guide the change process
- Developing *patient registries* to identify needed care and outliers from the practices' patient population
- Promoting *use of decision support tools and templates* to support practice workflow
- Encouraging *proactive, team-based care* with assigned roles and responsibilities to help providers engage patients throughout the entire visit process
- Implementing *evidence-based protocols and clinical algorithms* to encourage the use of standing orders and clinical decision support tools in the EHR
- Enhancing *self-management support* for patients within the practice and developing a strong process of referral to external patient support resources

Update

- The first of two waves of the intervention has begun, with 108 practices that have had at least one contact with their practice facilitator between January and April 2016.
- Facilitators are finding that helping practices with their EHRs is the primary focus of their support. They are increasing practices' awareness of the importance of documentation and ensuring that staff are inputting the right data in the right fields so that the data needed for reporting ABCS measures can be extracted.
- Facilitators are encouraging practices to think about population health by using risk assessment data, specifically the pooled atherosclerotic cardiovascular disease (ASCVD) calculator,[5] to estimate 10-year and lifetime risks for ASCVD. The goal of the risk assessment is to identify patients who will benefit from preventive care more acutely, although all patients will eventually be targeted for intervention.

Evaluation

The cooperative is conducting a stepped-wedge, stratified, cluster randomized trial, where the practices are randomized on geography (East vs. West) and degree of practice readiness for change (determined by the Organizational Readiness for Implementing Change [ORIC] scale[6]). Based on the results of the practice readiness stratification and subsequent follow-up with practice facilitators early in the intervention, practices were placed in either a high-readiness or low-readiness intervention wave. Each practice will enter a maintenance period 12 months after starting the intervention, where practice facilitators are available to support practices on an as-needed basis.

Update

- The first of three cohorts of practices in the high-readiness wave began receiving the intervention in January 2016, with two subsequent cohorts within that wave beginning the intervention in March and May 2016.
- The low-readiness wave will roll out beginning in July 2016.

Strategies for Disseminating Study Findings and Lessons Learned

Update

- The cooperative is in the early stages of refining its communications strategy. The cooperative has developed a Web site with information about the initiative and a portal with content for participating practices. The cooperative plans to use this platform to disseminate findings and is also considering submitting publication and presentation abstracts for the 2017 cycle of conferences, including the American Public Health Association, Academy Health, and the Society of General Internal Medicine conferences.
- A descriptive paper about the cooperative's project was published in 2015 (Weiner BJ et al. Advancing Heart Health in North Carolina Primary Care: The Heart Health Now Study Protocol. *Implementation Science* 2015;10:160).

EvidenceNOW
Advancing Heart Health in Primary Care

North Carolina Cooperative

SPOTLIGHT ON RECRUITMENT

Comment from Principal Investigator

Samuel Cykert, M.D.

"Practices are a bit overwhelmed in the run-up period to the project by all the change and uncertainty in their local environments and feeling like they have just another thing to do. However, once they are touched by the practice facilitators and realize their skills and goals, no one drops out. This shows the power of the coaches and the heart of the participants to do good."

Recruitment Specifics

The cooperative has nearly reached its recruitment goals, with 253 practices enrolled or verbally committed by May 1, 2016, with a recruitment target of 270 practices. The cooperative recruited and randomized 108 practices in the first wave, which began in January 2016; 150 practices have been recruited or have verbally committed to the second wave. The cooperative is aiming for 160-170 total practices in the second wave.

Factors that Contributed to Recruitment Success

- **Relationships:** The practice facilitators have longstanding relationships with local practices though their involvement in the North Carolina Area Health Education Centers Program. The recruitment and data analytics staff at Community Care of North Carolina also have worked with many practices in previous data exchange and analytics projects. These relationships were a key driver of recruitment.
- **Building capacity to respond to policy change:** Small practices in North Carolina are motivated to improve their data extraction and analytic capabilities for quality improvement and measure reporting, so they can be ready for policy and reimbursement changes related to value-based payment reforms. EvidenceNOW supports both of those capabilities.

Challenges to Recruitment and How the Cooperative Responded

- **Limited resources and competing practice transformation:** Practices were concerned that working with the cooperative would require excessive time or resources on top of their existing clinical and administrative responsibilities, especially in light of competing initiatives, such as the Transforming Clinical Practice Initiative (TCPI). Helping practices understand that the support from the cooperative would help them build infrastructure that could be leveraged for other initiatives, such as TCPI, and imminent policy changes, such as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), provided a rationale for the investment of their participation in EvidenceNOW.

[1] *http://quickfacts.census.gov/qfd/states/37000.html. Accessed May 24, 2016.*

[2] *http://www.americashealthrankings.org/NC/CVDDeaths. Accessed May 24, 2016.*

[3] *North Carolina Department of Health and Human Services. Health Profile of North Carolinians 2011 Update; 2014.*

[4] *Yoon SS, Ostchega Y, Louis T. Recent trends in the prevalence of high blood pressure and its treatment and control, 1999-2008. NCHS Data Brief 2010 Oct;48:1-8. PMID: 21050532.*

[5] *American College of Cardiology. ASCVD Risk Estimator Update 2014. http://tools.acc.org/ASCVD-Risk-Estimator/#page_about*

[6] *http://www.implementationscience.com/content/9/1/7*

Last updated date: May 24, 2016